



## MONTANA STATE HOSPITAL POLICY AND PROCEDURE

### USE OF RESTRAINTS FOR NON-VIOLENT NON SELF-DESTRUCTIVE BEHAVIORS

**Effective Date:** August 16, 2013

**Policy #:** TX-31

**Page 1 of 8**

- I. PURPOSE:** To provide guidelines for the appropriate use of restraints for the physical safety of patients with non-violent or non-self-destructive behaviors.
- II. POLICY:** Montana State Hospital (MSH) is committed to providing a safe environment in which patients have the right to be restraint free. Non-violent non-self-destructive restraints are used to promote medical healing and/or diminish patient risk of suffering physical harm. In the event that restraint is necessary to ensure the immediate physical safety of a patient and after alternatives have been attempted, the least restrictive method of restraint that meets the patient's assessed need may be utilized. Restraints will be discontinued at the earliest possible time. Seclusion is not utilized for the physical safety of patients with non-violent or non-self-destructive behaviors. The patient's rights, dignity and wellbeing will be protected and preserved by care providers. The use of restraints for coercion, discipline, convenience, or retaliation by staff is not permitted.
- III. DEFINITIONS:**
  - A. Restraint
    1. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his/her arms, legs, body, or head freely. The following are examples of devices that may be considered a restraint for the patient with non-violent non-self-destructive behaviors:
      - a. Safety devices that cannot be easily released by the patient such as a Pelvic Posey, Lap Buddy, pommel wedge, hand mitts that cannot be easily removed or are in conjunction with soft wrist restraint, use of four side rails to prevent a patient from voluntarily exiting a bed, use of a chair in reclined position with knowledge and intent that the patient cannot voluntarily exit, use of restrictive clothing (i.e. jumpsuit with zipper in back) that cannot be easily removed.
    2. A drug or medication used to manage a patient's behavior or restrict the patient's freedom of movement that is not a standard treatment or dosage for the patient's condition. Chemical restraint is not approved for use at MSH.
    3. A restraint **does not** include orthopedically prescribed devices (wheelchairs, braces, splints, casts, heel/elbow protectors, etc.) surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests. However, the patient has the right to refuse a medical exam. Devices such as bed rails to protect the patient from falling out of bed when the patient is experiencing

involuntary movement such as seizures or when a patient would be unable to voluntarily exit the bed due to his/her physical condition are not a restraint.

**B. Alternatives to Restraints**

1. Any mechanism that does not restrict a patient's movement or mobility, but may be effective in maintaining patient safety and wellbeing. Use of alternatives is based on individual patient assessment. Refer to Attachment A "Restraint Alternatives & Safety Interventions".

**C. Qualified Registered Nurse - A registered nurse who has received training and demonstrates knowledge in the specific needs of the patient population. The specific training and demonstrated knowledge include the following:**

1. Identifying staff and patient behaviors as well as environmental factors that may trigger circumstances that require the use of restraints for patients exhibiting non-violent non-self-destructive behaviors.
2. Identifying the risk of restraint use in vulnerable patient populations with cognitive and/or physical limitations.
3. Choosing the least restrictive interventions based on an assessment of the patient's behavioral and medical status
4. Identifying specific behavioral changes that indicate restraint is no longer necessary.
5. Monitoring the physical and psychological wellbeing of the patient in restraints.
6. Safe application of restraint.
  - a. Based on this training the qualified RN is authorized to initiate restraint and/or assess patients in restraint and assess their readiness for discontinuation of restraint.
  - b. Initial training will occur at the time of orientation, then subsequent education/competency annually.

**D. Licensed Independent Practitioner (LIP) - Physicians and Advanced Practice Nurses with prescriptive authority at MSH. LIP's will have initial education upon hire and annual education based on the needs of the patient population served.**

**IV. RESPONSIBILITIES:**

- A. MSH employees are responsible for supporting the commitment of MSH to reduce and or eliminate restraint use by utilizing less restrictive measures such as the alternative interventions listed in Attachment A.
- B. Staff Development shall conduct regular training upon hire and annually for staff involved in the use of restraints for non-violent non-self-destructive behaviors and alternative interventions.

- C. The Patient Safety Committee will perform an administrative review of restraint procedures.
- D. Restraint for non-violent non-self-destructive behaviors shall be utilized only to promote medical healing, diminish risk of suffering self-harm, to preserve the dignity and integrity of the patient when other less restrictive methods have been determined to be ineffective to protect the patient. Alternative approaches must be considered prior to the use of restraint.
- E. Reasonable efforts will be made to inform the patient, family, guardian/POA in the decision-making process about the use of restraints to include education on the use of restraint. Attachment B “When Restraints May Be Needed”.
- F. Staff shall make all efforts to preserve the privacy, safety, human dignity, and the physical and emotional comfort of the patient at all times.
- G. Staff shall ensure that the duration of the restraint procedure be the shortest time possible to reasonably assure the safety and protection of the patient.
- H. Staff shall implement restraint procedures in a manner to minimize potential medical complications. Staff must be aware of the possibility of patient injury during the application and utilization of restraints.
- I. Direct Care Staff, in close consultation with and direction from the LIP or Registered Nurse will:
  - 1. Promptly notify the LIP and/or the RN when a patient is at risk of physical harm, i.e.: falling; interfering with medical devices, i.e.: pulling at IV lines, feeding tubes; or compromising behavior, i.e.: disrobing.
  - 2. As directed, apply restraints safely and make adjustments as necessary in order to ensure that the patient is as physically comfortable as possible while restrained. No restraint or body positioning of a patient shall place excessive pressure on the chest or back of the patient or inhibit or impede the patient’s ability to breathe. Patients are to be restrained in a manner to minimize potential medical complications.
  - 3. Observe the patient every 15 minutes during procedure and as directed by LIP/RN and provide for the patient’s safety and comfort.
  - 4. Monitor vital signs at least every two hours or more often as directed. In the event the patient’s behavior renders this impossible or unsafe for either the patient or the staff this will be documented in the medical record.
  - 5. Provide a patient in restraints an opportunity for range-of-motion exercise for at least 10 minutes at least every two hours, unless the patient’s behavior renders this impossible or unsafe for either the patient or the staff or is contraindicated by condition of joint or limb.

6. Offer fluids at least every two hours or more frequently if the patient is dehydrated, unless fluids are restricted by a physician's order. Meals and snacks will be offered at regular intervals.
7. Offer the patient use of toilet facilities or a bedpan/urinal at least every two hours and/or in accordance with bowel/bladder plan and whenever a patient requests a need.
8. Provide care and comfort measures, i.e.: personal grooming/hygiene care.
9. Document patient's behavior, physical condition and care offered and provided including hygiene, diet, fluid intake, bowel/bladder functions, range-of-motion, and vital signs, in accordance with the following procedure.
10. Promptly inform RN about any changes in a patient's behavior or physical condition.

**J. Qualified Registered Nurses will:**

1. Assess the patient and situation, in collaboration with the LIP as soon as possible, to determine risk of immediate physical safety requiring the use of restraint. This assessment will include whether alternatives to the use of restraint have been adequately attempted or considered, possible causes of behavior, risks associated with the use of restraint including pertinent medical health issues.
2. Obtain verbal or written order from the LIP for the procedure prior to implementation or as soon as possible after an emergency implementation of restraint for non-violent non self-destructive behaviors. The order will include the method of restraint to be utilized, clinical rationale for use of procedure and criteria the patient must meet for release/removal from restraint. The order must state, face to face monitoring every 15 minutes and release from restraints every 2 hours. Releasing the patient for range of motion, toileting and exercise does not require an order renewal.
3. Assess the patient face-to-face as soon as possible and at least within one hour after initiation of a restraint procedure, when LIP not available to do so.
4. Notify and consult with the LIP as soon as possible upon completion of initial assessment.
5. Notify the patient's attending LIP by phone or as soon as possible regarding the restraint procedure.
6. Assess the patient in restraint at least every two hours and document in accordance with the following procedure.

7. In special circumstances, a patient in restraint may be able to rest in bed safely without restraint and may require continuation of restraint while awake. This circumstance does not require an order renewal. The RN must assess the patient and provide additional documentation on progress notes when the patient is placed back in restraint.
  8. The RN will document, times of restraint placement and times of restraint release on the RN Progress Note.
  9. Ensure the treatment plan is updated when restraint application occurs.
- K. Licensed Independent Practitioners (LIP) will:
1. Assess and give orders authorizing the use of restraint procedures; conduct a face-to-face evaluation of the patient and sign the order within twenty four (24) hours of the initiation of restraint and every 24 hours thereafter.
  2. Ensure informed consent from the patient and/or guardian/POA for the use of restraints and patient/family education on use of restraint.
  3. Ensure assessment of the patient to determine that the benefits associated with the use of restraint outweigh the risks.
  4. Ensure that the treatment plan is updated when restraints are implemented.
  5. Assess and document in accordance with the following procedure.
  6. Notify the Hospital Superintendent or designee of all patient deaths.
- L. Quality Improvement Director is responsible for tracking use of these procedures throughout the hospital and disseminating data about use of restraint to appropriate staff members. This will include tracking all patient deaths and related use of restraints with reporting to the Hospital Superintendent or designee.
- M. Hospital Superintendent or designee is responsible for promoting activities that ensure the safety of patients and lead to a reduction in the use of restraint procedures for patients exhibiting non-violent non-self-destructive behaviors. This will be done through analysis of incidents that do occur and utilizing information to improve staff skills and patient treatment. The Hospital Superintendent will report deaths to CMS in accordance with following procedure.

**V. PROCEDURE:**

1. Patient will be assessed for potential restraint use based on the following criteria (must meet at least one):
  - a. Inability to ambulate safely with repeated attempts to do so.
  - b. Behavior which threatens the safety of patients with invasive tubes and lines.
  - c. Behavior which seriously compromises the dignity of the patient (i.e. disrobing in front of others).

2. Guidelines for the appropriate use of any restraint.
  - a. The dignity of the patient is to be maintained at all times.
  - b. Reasonable efforts will be made to inform the patient, family, guardian/Power of Attorney in the decision-making process about the use of restraints. Benefits, alternatives, and risks to restraints, and consequences of refusal will be discussed. Such efforts will be documented in the medical record.
  - c. Patient/family/guardian education on use of restraint will be completed and documented.
  - d. The least restrictive type of restraint will always be the first choice.
  - e. A comprehensive assessment of the patient must determine that the benefits associated with restraint use outweigh the risk of not using it.
3. Assess and attempt to address for possible causes of behavior. Consult with other health care team members as necessary. Consider:
  - a. Abnormal lab values (Na, K, glucose)
  - b. Hypoxia
  - c. Pain or discomfort
  - d. Urinary retention, urinary tract infection, or fecal impaction
  - e. Drug or alcohol intoxication/withdrawal
4. Orders for restraints are obtained by the Registered Nurse prior to application of restraints. In some situations, however, the need for a restraint intervention may occur so quickly that an order cannot be obtained prior to application of restraint. In these emergency situations, the order must be obtained either during the application of the restraint, or as soon as possible after the restraint has been applied. The order will include the reason, type of restraint, risk versus benefits and alternatives attempted as applicable. The order will be dated, timed and signed appropriately.
5. An LIP will conduct a face-to-face evaluation of the patient and sign the order within twenty four (24) hours of the initiation of restraint.
6. A new order is required every 24 hours for continued restraint use. The order renewal requires a face-to-face evaluation by an LIP.
7. LIP orders and assessments/evaluations regarding the use of restraint will be documented on the Restraint Order and Progress Note form (Attachment C).
8. PRN orders for restraint application are prohibited.
9. Restraints will be applied according to manufacturers' guidelines.
10. Direct care providers will observe the patient in restraint at a minimum of every 15 minutes to ensure patient safety, comfort and the provision of care with documentation in accordance with MSH Observation Flow Sheet (Attachment D).

11. RN's will monitor the patient in restraint within one hour after initiating the restraint and at least every two hours to assure that restraint remains indicated, restraining devices remain safely applied, and that the patient remains as comfortable as possible and care needs are met. This assessment will include the following:
  - a. Vital Signs (may not be necessary if sleeping)
  - b. Circulation
  - c. Clinical justification
  - d. Skin integrity
  - e. Nutrition and hydration needs
  - f. Hygiene and elimination needs
  - g. Least restrictive restraint in use and applied properly
  - h. Behavior and comfort level
  - i. Range of motion
  - j. Turning/repositioning

The requirement for 2-hour assessments may be modified upon written order of the LIP as authorized by the Medical Director or Hospital Superintendent. Modification must be based on the patient's individual circumstances taking into consideration such variables as to the patient's condition, risks associated with use of restraint, and other relevant factors.

12. RN will document initial and two hour checks and no less than daily progress notes on the Restraint Flow Sheet (Attachment E).
13. In special circumstances, a patient in restraint may be able to rest in bed safely without restraint and may require continuation of restraint while awake. This circumstance does not require an order renewal. The RN must assess the patient and provide additional documentation on progress notes when the patient is placed back in restraint.
14. The RN will document, times of restraint placement and times of restraint release on the RN Progress Note.
15. The patient's treatment plan will be updated when restraint application occurs.
16. Restraint must be discontinued at the earliest possible time and may be directed by an LIP or qualified RN based on their assessment.
17. In the event a patient requires restraint on an on-going basis the LIP in collaboration with other members of the treatment team will reevaluate the patient for strategies to be used in place of restraints as well as the patient's response to restraint procedure.
18. The Hospital Superintendent or designee will report to CMS each death that occurs while a patient is in restraint; each death that occurs within 24 hours after the patient has been removed from restraint or each death known to the hospital

## Montana State Hospital Policy and Procedure

### USE OF RESTRAINTS FOR NON-VIOLENT NON SELF-DESTRUCTIVE BEHAVIORS

Page 8 of 8

that occurs within one week after restraint has been removed when it is reasonable to assume that the use of restraint contributed directly or indirectly to a patient's death such as deaths related to restrictions of movement for prolonged periods of time, related to chest compression, restriction of breathing or asphyxiation. This report will be made to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death. Documentation of the date and time of this reporting will be entered into the Progress Notes of the patient's medical record.

- VI. REFERENCES:** Standards/Statutes: 53-21-146 M.C.A.; M.C.A. 53-21-147 Patient Rights; CMS 42 CFR Part 482 conditions of participation for hospitals, Subpart B – 482.13 Patient Rights and, (f) Seclusion and Restraint for behavior management; MSH Policy #TX-16, *Use of Seclusion and Restraint*
- VII. COLLABORATED WITH:** Hospital Superintendent, Medical Director, Director of Nursing
- VIII. RESCISSIONS:** #TX-32, *Use of Restraints For Non-Violent Non-Self-Destructive Behaviors* dated April 30, 2013; #TX-31, *Use Of Restraints For Non-Violent Non-Self-Destructive Behaviors* dated November 9, 2010.
- IX. DISTRIBUTION:** All hospital policy manuals
- X. REVIEW AND REISSUE DATE:** August 2016
- XI. FOLLOW-UP RESPONSIBILITY:** Director of Nursing
- XII. ATTACHMENTS:** Attachment A: [Restraint Alternatives & Safety Interventions](#)  
Attachment B: [When Restraints May Be Needed](#)  
Attachment C: [Restraint Order and Progress Note Form](#)  
Attachment D: [MSH Observation Flow Sheet](#)  
Attachment E: [Restraint Flow Sheet](#)

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John W. Glueckert                      Date  
Superintendent

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Thomas Gray, MD                      Date  
Medical Director

## Restraint Alternatives and Safety Interventions

Alternative	Intervention
Obtain information and/or assistance from family, friends, guardian, prior care providers, peer support specialists.	<ul style="list-style-type: none"> <li>When appropriate, encourage family/others intervention as much as possible to sustain patient orientation and keep the patient occupied and accident-free.</li> </ul>
Bowel/Bladder assessment	<ul style="list-style-type: none"> <li>Implement a bowel/bladder regimen for the patient as needed, or at minimum, check that elimination needs are being met on a consistent basis.</li> </ul>
Exercise or position changes	<ul style="list-style-type: none"> <li>Take patient for a walk.</li> <li>Turn every 2 hours if immobile.</li> <li>Regular exercise may eliminate or diminish restlessness and possible agitation.</li> </ul>
Patient Safety Devices	<ul style="list-style-type: none"> <li>Utilize supportive/assistive devices instead of restraints as appropriate, i.e. bed alarms or chair alarms.</li> <li>Verify patient has walker, glasses, hearing aide, etc.</li> <li>Educate patients and families as appropriate.</li> </ul>
Distractions	<ul style="list-style-type: none"> <li>TV/no TV</li> <li>Hand activity</li> <li>Music</li> <li>Coloring books, magazines, word find, crossword puzzles</li> <li>Snacks</li> <li>Therapeutic touch/massage</li> <li>Card games</li> </ul>
Environmental	<ul style="list-style-type: none"> <li>Room close to the nurse's station as able.</li> <li>Use Comfort Room as able.</li> <li>Provide a quiet environment (↓ stimulation).</li> <li>Minimize sleep disturbances as able.</li> <li>Assess for appropriate lighting; change lighting options.</li> <li>Place a strip of tape across the door or on the floor to help direct patients.</li> <li>Place a large STOP or DO NOT ENTER sign on the door to help direct patients.</li> <li>Keep room free of obstacles.</li> <li>Keep personal items, call light, bedside stand, etc. within reach.</li> </ul>
Reality Orientation	<ul style="list-style-type: none"> <li>Reorient patient as needed. Place patient name on door inside the room. Consider use of eraser board with name and date.</li> <li>Include family as able.</li> <li>Family/pet photos in the room.</li> </ul>
Medication Reassessment <ul style="list-style-type: none"> <li>◆ Examples include: analgesics, anti-convulsants, antidepressants, antihistamines, antiparkinsons, antiemetics, gastrointestinal, anxiolytic/hypnotics, muscle relaxants, antipsychotics, corticosteroids, antiarrhythmics.</li> </ul>	<ul style="list-style-type: none"> <li>Review medication administration times of diuretics, antihypertensive, laxatives, etc., and correlate with bowel/bladder routines.</li> <li>Assess for pain and assist in pain management.</li> <li>Review medication times for behavioral response.</li> <li>Review medication list for any that may cause or be contributing to the patient's conditions and report to the physician.</li> </ul>
Referral and/or reassessment	<ul style="list-style-type: none"> <li>Rehab therapy</li> <li>Occupational therapy</li> <li>Psychology</li> </ul>
Increased level of observation: 15 min checks, 1: 1 staffing (requires LIP order)	<ul style="list-style-type: none"> <li>Staff remain actively engaged with the patient when he/she is not resting.</li> </ul>

## **Montana State Hospital**

### **When Restraints May Be Needed**

#### **Information for patient and families**

*MSH is committed to providing quality care for all our patients in a safe and respectful manner.*

**Why would a patient require restraint?** Patients who have been alert and oriented may become confused and unable to cooperate with their care and treatment when ill. This change may be caused by a physical and/or mental illness, unfamiliar surroundings, a change in daily routine, sleep patterns or medication.

**Alternatives to restraints that may be considered...**Staff members may only need to provide reassurance or explanations and closer observation to insure the patient's safety. In more serious situations, a change in medication or treatment may be necessary to keep the patient safe.

#### **What are other possible alternatives?**

- Appropriate exercise such as walking or change in positioning
- Alter lighting or decrease noise
- Offer diversional activities (TV, music, singing, card games, magazines, puzzles, crafts)
- Make sure patient has personal items when appropriate such as hearing aids, glasses, walker
- Use patient safety devices as needed, such as bed or chair alarms, quick release belts, and rehabilitation support appliances

#### **How can family and friends help?**

Often a visit from a familiar person can be beneficial in calming an anxious or confused person. The knowledge and availability of loved ones can be an important resource to the health care team in maintaining patient safety. Staff may suggest to family members and friends to bring favorite pictures, books, or music.

*Ask staff for information about other resources.*

**If alternatives are not satisfactory...**In some cases, the alternatives discussed are not sufficient to keep the patient safe. If the patient demonstrates behavior that could harm him/herself, or seriously interferes with treatment (i.e. pulling at tubes or lines which could result in serious injury if removed) a restraining device may be needed to maintain safety.

#### **Restraints**

These devices may include waist support or wrist restraints. In all cases, the least restrictive device possible will be used. You should also know that these devices may only be used with the advice and approval of the physician. During the period when such devices are in use, staff will continually reassess their necessity and discontinue or change to a less restrictive method as soon as possible.

**Special care will be given...**While a person requires restraints; the nursing staff recognizes that they have special responsibilities to provide care, comfort, emotional support and attention to such needs as fluids, nourishment, use of the toilet or bedpan, and changes in position. An individual in restraints is observed very closely by the staff and his or her needs are attended to with concern for comfort, privacy and dignity.

**What you need to know...**When the decision to use a restraint is being considered (or must be made in case of an emergency), the staff will make every effort to inform you as soon as possible. They may also seek advice for other possible strategies to help keep the patient as safe and comfortable as possible. We encourage ongoing discussion of your concerns. Please feel free to consult with your physician or nurses caring for you or your family member if you have any concerns or questions.

### **Montana State Hospital Guiding Principles**

- Keep people safe.
- Treat people with respect, trust and dignity.
- Consider all patient needs with sensitivity.
- Utilize a holistic approach for the provision of care.
- Assist patients toward achieving greater levels of self-sufficiency and autonomy.
- Support informed choice and decision-making.
- Advance the mission of the hospital through teamwork.
- Ensure public trust through personal and professional integrity

**MONTANA STATE HOSPITAL**

**LIP Order & Progress Note**

**Restraints for Non Violent/Non Self-Destructive Behaviors**

LIP Order and face to face assessment (documented on Progress Note on back of form) required every 24 hours.

Renewal Orders cannot be phone orders.

**Patient Name:** \_\_\_\_\_ **MSH #:** \_\_\_\_\_ **Unit:** \_\_\_\_\_

**Reason for Restraint (related to immediate physical safety):** \_\_\_\_\_

**Risk factors versus benefits of restraint use:**

Risk Factors: ☐ Falls ☐ Accidental Hanging or Strangulation ☐ Weak Muscles ☐ Skin breakdown ☐ Not Being Able to Move or Walk as Well ☐ Stiffness ☐ Loss of Bone Mass ☐ Agitation or Confusion ☐ Frustration ☐ Loss of Dignity ☐ Loss of Bladder Control ☐ Constipation ☐ Other: \_\_\_\_\_

Benefits: \_\_\_\_\_

**Alternatives Considered/Attempted Prior to Intervention:** ☐ Bowel/Bladder assessment ☐ Exercise or position changes ☐ Patient safety devises ☐ Distractions ☐ Environmental ☐ Reality orientation ☐ Medication reassessment ☐ Referral and/or reassessment ☐ Increased level of observation ☐ Redirection ☐ Comfort measures

☐ Other (specify): \_\_\_\_\_

**Pertinent Medical Health Issues:** \_\_\_\_\_

**Type of Restraint Ordered:** ☐ Pelvic Posey ☐ Lap Buddy ☐ Jumpsuit ☐ Other (specify): \_\_\_\_\_

**Release criteria (as specified by LIP):**

**Nursing care will include:** 15 minute checks by Psych Techs to provide for patient safety and comfort; RN assessment every 2 hours; the patient in restraints must be released every 2 hours for ROM, toileting and exercise. Modifications must be specified: \_\_\_\_\_

**If the patient in restraint is released for care or for sleep in bed (without restraint), the restraint order is still valid for 24 hours and the restraint procedure may be continued.**

**The restraint order must not exceed 24 Hours**

☐ Attending LIP Notified (**Initial Order**) VO/PO RN: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
LIP Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**MONTANA STATE HOSPITAL**  
Physician/LIP Progress Note

[illegible]

# MONTANA STATE HOSPITAL OBSERVATION FLOW SHEET

[illegible]

[illegible]

# Montana State Hospital

## Non Violent/Non Self Destructive Restraint Flow Sheet

RN must document progress note on back of form daily. RN assessments required every 2 hours and every time patient is out of restraint for hours of sleep. Provide additional documentation on progress notes when placed back in restraints.

Patient Name: \_\_\_\_\_ MSH #: \_\_\_\_\_ Unit: \_\_\_\_\_

Date Time	T	P	R	B/P	O2 sat Cap refill	Release q 2 hours	Skin Integrity	Nutrition/ Hydration	Hygiene/ Elimination	Behavior	Clinical Justification	Least Restrictive Restraint Applied Properly	Range of Motion	Turning Reposition	Initials
Comments															
Comments															
Comments															
Comments															
Comments															
Comments															

### Behavior Key

CL = calm  
SL = sleeping  
T = tension  
E = excitement

DO =disoriented/confused  
V = verbal outbursts

### Skin Integrity

I = intact/normal  
O = other with comment

### Nutrition/Hydration

M = meal  
S = snack  
F = fluids  
R = refused  
A = Asleep

### Hygiene/Elimination

U = urine  
S = stool  
IU = incontinent urine  
IS = incontinent stool  
D = Dry

### Cap refill

WNL – less than 3 seconds  
If greater 3 seconds,  
intervene and document

### Clinical Justification

- 1 – Alternative Attempted/documentated unsuccessful
- 2 – Inability to ambulate independently; attempting to do so; at risk for physical harm
- 3 – Behaviors that threaten safety of invasive devices/dressings/treatments
- 4 – Behaviors that seriously compromises dignity/safety

### Type of Restraint Applied Properly

PP = pelvic posey  
LB = lap buddy  
JS = jumpsuit  
PW = pommel wedge  
O = other: \_\_\_\_\_

Date	Signature	Date	Signature

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RN Progress Note

[illegible]